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SURGICAL CASES OCCURRING IN THE MASSACHUSETTS GENERAL HOSPITAL. SERVICE OF DR. HENRY J. BIGELOW.—NO. VIII.

ANEURISMAL VARIX. LIGATION. LIGATION OF COMMON CAROTID. RECOVERY.

Reported by HENRY H. A. BEACH.

[Communicated for the Boston Medical and Surgical Journal.]

S. B., æt. 23. This patient, a young lady of delicate appearance and organization, entered the hospital May 1st, 1867.

When about five years of age, fell and struck her head upon a sharp knife, producing an incised wound of about half an inch, above the superior border of the zygomatic process of the temporal bone and over the temporal artery, probably wounding it, with the vein, there being considerable hæmorrhage at the time, which was checked by direct compression, though without the assistance of a surgeon. Very soon after the wound healed, a pulsating tumor, of the size of a pea, appeared at the point of injury and gradually increased, unaccompanied with pain, until about last March. From that time until May its growth was rapid. Upon examination, Dr. Bigelow stated:—"At the point described, the elevation is about three quarters of an inch above the surface, with a heavy thrill and pulsation, and to the ear a continuous roar. The pulsation and thrill extend over a surface of about three inches and a half in vertical diameter, and two inches transversely, at the broadest point. The tumor is found to consist of tortuous and pulsating veins, the largest of which is of the size of the little finger. These are supplied with blood by the temporal artery, which seems to be more than one quarter of an inch in diameter. The communication between these vessels is free, both at the point of puncture and at their periphery. Compression of the carotid, or at the punctured point, causes a diminution in the size of the tumor, but at the same time greatly enlarges the surrounding veins by obstructing the return of venous blood. It also produces dizziness and a sensation of distress."

Operation.—Patient was etherized. A ligature was placed beneath the carotid artery, below its bifurcation, to control the circula-

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tion. The veins were found generally enlarged, requiring some care in reaching the vessel. A straight incision of four inches was then made over the long axis of the tumor, through the integument, and the two flaps dissected from the pulsating surface. Two long, curved needles were passed transversely beneath the pulsating mass—one, half an inch below the superior border, and the other the same distance above the inferior border, after having been entered between the flap and the tumor, at the point where the dissection was discontinued; leaving half of an inch of each needle exposed, and over the reflected flaps of both sides. Compression was now applied by a stout ligature describing a figure of eight over each needle and between the two needles. Even this procedure failed to arrest the pulsation at the periphery. The ligature which had been placed beneath the carotid artery was therefore tied, leaving the tumor still pulsating a little at its upper part. The wound in the neck was closed by five sutures. Cold-water dressing. Diet of oatmeal gruel and milk. Opiate when indicated.

May 5th, 8, A.M.—Pulse 108. Complaints of slight sore throat and pain about wound of face. 2, P.M.—Slight oozing of blood from wound of face. 8, P.M.—Comfortable. Pulse 90, regular, and a little stronger in the right than in the left radial.

6th.—Still complains of pain about wound of face. Urine is drawn by catheter. Right cheek and eye slightly swollen.

7th, 1, A.M.—Nurse reported hæmorrhage from wound of face. The bleeding vessel was tied. Wound left exposed to the air. 6, A.M.—Quite restless with pain about wound of face. Pulse 72, and weaker. *R.* *Tr.* *opii* gtt. xxx. 2, P.M.—Very comfortable. Edges of wound of face are red and swollen. Tongue slightly coated. 8, P.M.—Pulse 144, but regular and of good strength. "Throat is not so sore." Suppuration has commenced in wound of the face. Strangulated portion is of a dark-blue color.

8th.—Pulse 132, and stronger.

9th.—Pulse 130. Both wounds are discharging freely.

10th.—Pulse 120. Passed a comfortable night without an opiate.

11th.—Pulse 140, regular, but not so strong as yesterday. There is oozing of blood from wound of face upon slightest exertion. Sutures removed from wound of neck. 7, P.M.—Pulse 144, regular, but considerably weaker. Restless. Has pain in head and throat. Extremities getting cool. Countenance anxious and expressive of distress. *R.* *Tr.* *opii* gtt. xxx., now. Strong beef-tea in such quantities as she can bear without nausea. Heaters to feet. 9, P.M.—Sleeping quietly. Pulse 130, regular and stronger. Skin hot and dry.

12th, 6, A.M.—Comfortable. Pulse 130, weaker. 10½, A.M.—Hæmorrhage from three separate points in wound of face, which was checked by local application of liquor ferri subsulphatis. Pulse 135, weaker. Continue beef-tea. *R.* *Tr.* *opii* gtt. xxx., now. 5, P.M.—

The pulse had now become so small as to give rise to serious apprehension. Integument of cheeks erythematous, with itching and slight induration. Has slight pain in wound of face. 7½, P.M.—Nurse reported hæmorrhage from wound of face. Upon examination, it was found proceeding from six different points, accompanied with a very weak pulse, so rapid that it could not be counted; skin pallid and cool. The hæmorrhage was checked with difficulty by compression and application of liquor ferri subsulphatis. Dr. Bigelow was called, and until he arrived (in twenty minutes), stimulants were freely administered, but with so little effect that it was not deemed by him judicious to etherize her for the following operative measures.

Operation.—Dr. Bigelow removed, with scissors, the whole strangulated mass, including needles, dried coagula and ligatures, tied the bleeding points, and applied direct compression, by means of sponges soaked in liquor ferri subsulphatis, to the whole raw surface. The administration of stimulants was continued, the temperature of the apartment kept at 70° F., head of bed raised five inches, and heated sand-bags applied to extremities, until her pulse could be counted, at 1 o'clock, A.M., of the 13th, 200. 6, A.M.—Pulse stronger. No more hæmorrhage. 8, P.M.—Pulse 144, stronger and regular. 10, P.M.—Pulse 168, weaker; extremities cool. The administration of strong beef-tea and brandy was continued.

14th, 3, A.M.—Pulse 144, stronger. No pain. 5, A.M.—Pulse 135. Integument about wound of head swollen and indurated.

15th, 7, A.M.—Pulse 144, regular, and of good strength. Good appetite. Asks for ale, with ice. Six ounces of ale. 12, M.—Pulse 150, strong and regular. More swelling about wound of face. Complains of sore throat. 7, P.M.—Pulse 150. Very comfortable, with exception of sore throat.

16th, 7, A.M.—Pulse 144, full and regular. Free discharge of pus from wound of face. Passed a comfortable night. 7, P.M.—Pulse 132.

17th, 7, A.M.—Pulse 132. 4, P.M.—Pulse 144, full and regular. Slightly delirious. Discontinue opiate. 8½, P.M.—Pulse 160, full and strong. Still delirious. Apply heaters to feet and compress wet with cold water to head.

18th, 7, A.M.—Slight epistaxis; checked by local application of solution of tannic acid in water—gr. x.— $\frac{3}{4}$ i. 7, P.M.—Pulse 120. Skin moist and warm. Free discharge from wound of face, with fœtor. No delirium.

19th.—Compression removed, displaying a fresh granulating surface, which fully occupied the area of the former pulsating tumor. Pulse 120. Good appetite. Simple water-dressing to wound of head.

20th.—Pulse 114.

29th.—Improvement in every respect since last report. Wounds look well and discharge freely. Ligature of the carotid removed.

June 13th.—Pulse 120, regular, and of good strength. Good appetite. Both wounds still discharge, freely, healthy pus, and are gradually closing. *R.* Tr. ferri chloridi, gtt. v. ter in die. Steak, chop, eggs, &c., for diet.

21st.—Up and dressed for the first time.

26th.—Granulations of the wounds are pale. *R.* Ferri et quiniæ citratis, gr. lxxx.; syrupi, ʒ ss.; vini Xerici, ʒ viiss. *M.* ʒ ss. ter in die.

29th.—Is gaining strength rapidly. Wounds are slowly closing. Allowed to go home and continue treatment.

23d.—Has continued to improve, both in strength and appearance, since last report. Only a small portion of each of the wounds remains unhealed. Appetite good. Takes moderate exercise daily.

Aug. 29th.—Has gained strength since last report. Wound of neck has entirely healed. That of the head has a small granulating surface of about one inch long by one quarter of an inch broad. Omit prescription of June 25th, and take of Blancard's pill (iodide of iron) one, night and morning. *R.* Olei morrhue ʒ ij. ter in die.

Oct. 1st.—Has gained twenty-seven pounds since July 1st. Wound has nearly healed.

28th.—Wound has entirely healed. The patient says:—"My general health is much better than before the operation." There is no deformity nor pulsation; the scar on the head is covered with the hair, and that of the neck is easily hidden by the collar. There is partial paralysis of sensation in the supra-orbital, superior maxillary and inferior maxillary regions of the right side of the face.

RECENT CONTRIBUTIONS TO THE ANATOMY OF THE TYMPANUM.*

By J. ORNE GREEN, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

THE dermoid layer of the tympanum is merely a continuation of the dermoid covering of the external meatus, which, at the external ear, contains all the elements of the cutis in full quantity, but gradually loses some of them as it proceeds inwards, and possesses the others in diminished supply, so that the layer becomes thinner and thinner as we examine from the outer ear towards the central point of the tympanum; the thinnest part is that a short distance from the hammer. Around the hammer itself this layer apparently becomes thicker; but, as we shall see, this thickening is due to a collection of

* Anatomisch-physiologische Studien über das Trommelfell und die Gehörknöchelchen. Von Dr. Josef Gruber, Docent der theoretischen und praktischen Ohrenheilkunde und Ohrenarzt des k. k. Allgemeinen Krankenhauses in Wien. 1867.

fibres separate from the dermoid layer, which descend in considerable quantity from the upper wall of the meatus.

By carefully preparing a tympanum under water, beginning from the inside and gradually removing the different layers till nothing but the dermoid layer remains on the glass, it is found that a band of connective tissue exists, which begins on the upper periphery with a basis of $1\frac{1}{2}$ "-2", and extends downwards on each side of the hammer till it reaches its lower end; that then the fibres separate, and some pass centrifugally into the dermoid layer, while the greater part pass round the umbo and unite with the fibres on the opposite side. This band of fibres contains the vessels and nerves supplying the tympanum, and also serves to bind a formation of cartilage which has heretofore escaped observation.

The hammer, throughout that part which is united to the tympanum, is imbedded in that membrane only to one third of its width, while the other two thirds are covered merely with the mucous membrane; this membrane apparently serving only to retain the hammer in its position. If, now, the hammer is removed by cutting through the mucous membrane along the neck and handle and then drawing the membrana tympani away, it is found, as a rule, that there is but an occasional and slight union between the hammer and membrane, which allows the two to be easily separated as far as the umbo; here, however, the union is found to be quite firm. On a tympanum so prepared can be discerned, either with the naked eye or by the touch, that exactly on that part corresponding to the small process and the handle, the membrane is more rigid than in its other parts and must contain other tissue elements. By a magnifying glass, it is seen that here is a cartilaginous formation having a distinct form, namely, that of a deep gutter closed at the upper end, and so forming, as it were, a cartilaginous cap for the small process of the hammer, while the other end is open, becomes more and more flattened, and loses itself gradually in the substance of the membrana propria. The whole form of this cartilaginous formation corresponds with the hammer, and individual peculiarities of the latter are also to be found in the cartilage; for instance, where the small process is but slightly developed the cartilaginous cap is found to be shallow, and *vice versâ*. Sometimes, but not always, there is the appearance as if the upper part of this cartilage, corresponding to the small process, was connected with the lower part, corresponding to the handle, by connective tissue. The best view of this cartilage is to be obtained in transverse sections, which show that the cartilage is thickest and most perfect, i. e., composed of the largest and finest cartilage cells, at the upper end, while at the lower end the cells are smaller and imbedded in a great measure in the fibres of the membrana propria. By separating these fibres, the cartilage cells can be found nearly one millimetre deeper than the deepest point reached by the handle of the hammer. Dr. Gruber has found this formation not only in

human tympana, but also in those of the horse, cow, sheep, pig, fox, hare, rabbit, dog, mouse, cat and rat.

On the anterior surface, the cartilage is lined with a thin layer of connective tissue, between which and the hammer a certain amount of synovial fluid is found. The space in which this fluid is contained begins on the rough part of the neck of the hammer (the spina) and continues some distance down the handle; it is usually most conspicuous on the anterior surface. In those cases where the hammer is separated from the cartilage with difficulty, which must be considered a pathological condition, this layer of connective tissue is even then found between them, showing that the two are never united directly together. The hammer has then the following position; above, attached by ligament to the roof of the tympanic cavity, and below, at the umbo, firmly to the tympanum, while the small process and the outer thirds of the surfaces of the handle lie free in a synovial fluid. Here we have all that is necessary to allow a rotary movement of the hammer in the direction of its long axis; and instead of the union of the hammer and tympanum being a rigid one, as was supposed, it is possible for certain parts of the hammer to move without the tympanum itself taking any part in such movement.

The tympanic cartilage is attached to the tympanum in a very complex way—by the band of connective tissue belonging to the dermoid layer which descends from the upper wall of the meatus, as previously described; secondly, by the fibres of the membrana propria which are inserted into it; and, thirdly, by connective tissue belonging to the cartilage itself, which descends from the upper part of the annulus tendinosus. The deeper fibres of the dermoid layer connect the cartilage with the tympanum, while the side fibres pass partly towards the periphery and partly unite the free edges of the cartilage with the surfaces of the hammer. The fibres from the annulus tendinosus run from the posterior upper end of the tympanic ring obliquely forwards and downwards, and are in this direction more tensely stretched; as soon as they reach the lower end of the neck of the hammer, they turn in circular bands around the cap-shaped end of the cartilage, which they partially cover outwardly, so that while they serve above for a uniting band between the hammer and annulus tendinosus, they also serve to bind the hammer to the cartilage around the base of the small process. Some slight bands of these fibres also pass towards the anterior and posterior segments of the tympanum, so that in the neighborhood of the hammer a ligamentous apparatus is formed which serves to fasten the cartilage in the tympanum, to unite it with the hammer, to strengthen the tympanum and to conduct the vessels and nerves.

The radial fibres of the membrana propria are inserted, not as usually described, on the hammer itself, but on the tympanic cartilage: viz., the fibres of the lower half of the tympanum on the lower part of the cartilage, and those of the upper half on the upper part,

except that in the extreme upper portion of the tympanum, on a spot more than a millimetre in diameter, the radial fibres are greatly diminished in quantity or entirely wanting, which explains why, after applying the air-douche in some cases, small, glistening projections are seen; for the tissue, being here thinner, is blown outwards, and small bladders of air are formed. These circular fibres, which in their course reach the cartilage, are inserted into it in the same way as the radial ones, only a very few of them being inserted on the hammer itself. A small number, however, are inserted neither into the cartilage nor the hammer, but seem to run, as von Tröltsch says, over the small process and before the neck.

While, heretofore, the *membrana propria* has been described as consisting of radial and circular fibres only, we find now that a third course of fibres are described, which, rising from the upper segment of the annulus tendinosus, run obliquely downwards towards the median line and on both sides of the tympanic cartilage, and so cross obliquely the course of both the radial and circular layers. They are to be found best developed in the posterior segment of the tympanum, and lie, as can be seen by careful dissection, outside of the radial and circular layers, and next the dermoid covering.

Still another formation in the tympanum is described by Dr. Gruber, which he names the ramifying fibres. By carefully removing the whole dermoid layer and the epithelium of the mucous membrane from the tympanum, these can be seen by a very slight magnifying power, and from their form and position they apparently play an important part in the physiology of the tympanum. This hitherto undescribed tissue consists of bands of fibres varying in size and shape, scattered irregularly over the whole surface of the *membrana propria*, but always to be found in the greatest quantity on the posterior segment. They take their origin from several small masses of fibres like the roots of a tree; these soon run together, form a band of variable width and length, and soon separate again into a number of smaller bands, which are gradually lost in or assimilated with the fibres of the *membrana propria*. The peripheral ends of these bands are situated on the inner surface of the *membrana propria*, and only covered by the mucous membrane, while, as they run towards the centre, they pass outward, and are to be seen between the circular and radial layers. These fibres are of the same nature as those of the *membrana propria*, namely, connective tissue, and probably serve to help the tympanum return to its normal position when too much stretched, either by the pressure of air or by muscular action. All these different layers of the tympanum are connected together by a delicate connective tissue.

The tensor tympani muscle, instead of being inserted, as von Tröltsch says, on the inner border and neck of the hammer, inserts part of its fibres on the inner border, while the larger part are inserted on the upper portion of the handle, directly under the chorda

tympani; and what Toynbee describes as the tensor tympani ligament is nothing more than the mucous membrane which covers all the parts within the tympanic cavity, and which, coming from the processus cochleariformis, surrounds the tensor tympani muscle like a sheath, and from it is distributed over the inner surface of the tympanum.

From what has been said of the insertion of the hammer in the tympanum, of the insertion of the ligament of the tensor tympani muscle in the hammer, and from the direction of the muscle itself, it is evident that during contraction not only will the tympanum be drawn inwards and stretched, but the hammer will rotate on its long axis, and the posterior surface of the handle will be turned outwards. An inspection of the articulating surface of the head of the hammer confirms this view, for it will be found that this describes a spiral from above and outwards, downwards and inwards, "running obliquely from the median line (externally) downwards over the posterior surface of the head, and forming a part of the median surface (internally) with its lower end." It is very probable that if such a movement of the hammer was from any cause excessive, the incus, and finally the stapes, would be moved, and consequently an influence exerted on the fluid contents of the labyrinth.

Gruber's experiment shows this movement very satisfactorily; having exposed the tympanum externally, and the musculus tensor tympani in its bony canal, so that it can be seized with forceps, the tympanum and small bones being left in their normal position, a needle with a straight bristle attached is drilled into the small process perpendicularly to the plane of the tympanum. Now by drawing on the muscle, it is seen that the end of the bristle, which must describe the same movement as the small process in an exaggerated degree, describes the arc of a circle from backwards, outwards and upwards in a direction forwards, downwards and inwards, showing that the hammer not only is drawn inwards by the contraction of the muscle, but also turns on its longitudinal axis. The pathological appearances also point to the same result, as in secondary shortening of the muscle (Politzer) often more of the posterior surface of the handle than of the outer border of the hammer is to be seen in examination, and the outer border is drawn towards the anterior wall of the meatus. The two segments of the tympanum are differently affected by this contraction of the muscle, the posterior becoming nearly a plane surface, while the anterior is relaxed and becomes concave.

Several of the new formations here described are to be seen in the examination of patients, and it is also now well established that other anatomical parts previously considered invisible are occasionally to be seen, the knowledge of which is necessary to explain occasional appearances on the tympanum. The oblique fibres from the outer meatus are often to be seen in examination of patients with

catarrh; for the tympanum being drawn inwards, and the hammer turning on its long axis, this band of fibres is stretched, and becomes visible as a yellowish white line coming from the posterior upper wall and passing forwards and downwards towards the small process of the hammer. The fibres which serve to fasten the tympanic cartilage are often visible as yellowish white lines running downwards and backwards nearly to the middle of the tympanum; these were formerly considered to be the outer edges of the different parts of the hammer. It is not infrequent to see the edges of the niche of the fenestra rotunda as a grayish spot on the tympanum, and, if that membrane is very transparent, the descending process of the incus appears as a white line behind the handle. Occasionally the union of the incus with the head of the stapes is to be seen, and very seldom indeed one side of the stapes. The anterior and posterior folds of the tympanum, first described by Dr. Gruber as an important diagnostic point in the drawing inwards of the membrane in catarrh, run forwards and backwards from the small process of the hammer, and become more developed the greater the prominence of the small process. They are formed in a perfectly natural way by the small process pressing the expanded membrane before it, as would be the case in pressing at any one point on a tissue tensely stretched. If the small process is very prominent, a superior fold also is formed, and it is by no means unusual to see all three on the same tympanum.

Only by an exact knowledge of the minute anatomy can the appearances found in disease be explained, and Dr. Gruber, in these recent "studies," has already cleared away much that was misty in aural surgery.

Vienna, October, 1867.

TREATMENT OF NASAL CATARRH.

By W. W. GARDNER, M.D., of Springfield, Mass.

[Communicated for the Boston Medical and Surgical Journal.]

THE treatment of catarrh has been heretofore so generally a matter of temporizing that our medical bank in this respect is nearly bankrupt of ideas or facts. Undoubtedly this condition results from the unwillingness of patients to submit to means necessary for a radical cure, so long as they can get relief from "dry ups."

Recently, the introduction of the "nasal douche" has opened anew the field of investigation, and with hopeful prospects of adding to our knowledge of the treatment, and perhaps to the pathology, of the disease. My observations, while using the douche the past year, lead me to believe that the fœtor attending catarrh, and often its continuance, depends upon the retention of decomposed and dried

mucus and pus in some of the fossæ of the nose or pharynx. The following case is selected for illustration.

Mrs. P., aged about 25 years, married, four months pregnant, primipara, commenced treatment for catarrh March 1st, 1866.

History.—Catarrh commenced in infancy; fœtor often so offensive as to exclude her from society; discharges from the nose and throat very profuse.

Present Condition.—Pharynx, velum and palate uniformly congested; discharges of variable colors—green, yellow, white and bloody—and quite offensive to smell; also of dry scales, varying in size from a few lines to an inch in diameter, and two or three lines in thickness, of a greenish-gray color. These scales were dry upon one surface and moist upon the other, with purulent matter. When these scales came off by “hawking,” they would get into the pharynx, and often produce vomiting.

At first, I commenced the use of the douche, with an ounce of the chloride of sodium in a pint of warm water, washing the nose out once in four days, but after a few sittings the interval was shortened to one day. The patient occasionally omitted the douche a week, and at one time nearly three weeks. Sometimes, as much as a gallon of the salt solution was carried through the nose, and even then it would occasionally fail to remove the dry scales; but generally they were ejected by the patient within an hour after using the douche. Ammonix muriat., gr. viij. to a pint of the salt solution, was added during the later days of treatment.

Shortly after treatment commenced, improvement was manifest; the moist secretion changing from green to yellow, and then white, and lessening in quantity. The dry scales diminished in size and consistence, and became lighter in color, until they ceased wholly. May 26th, nearly three months after the douche was first used, the patient declared herself well, and was discharged. Since that time, with the exception of attacks of acute catarrh, which the douche immediately controls, she has had no further trouble.

I think it reasonable to infer that pregnancy in this case favored constitutional changes in the system necessary or conducive to recovery, but I do not believe that the dry scales would have come away rapidly enough to admit of healing of the surface from which they were cast off unless the douche had been employed.

I have used the douche with the salt solution, to which from five to ten drops of tincture of capsicum were added, in acute catarrh; and when within twelve hours from the commencement of the attack, it has been uniformly successful, either in promptly arresting the disease or greatly modifying it. Warm new milk is a pleasant substitute for salt, and more soothing. When the fœtor is troublesome, I have added from five to twenty grains of permanganate of potash to the salt solution; and Dr. G. L. Stebbins, of this city, informs me that he uses Labarraque's solution with good success in such cases.

In some cases, where there is a flabby condition of the mucous membrane, bitter tonics, particularly "muriate of hydrastia," seem to assist in improving the symptoms better than astringents. In all instances, the constitutional treatment of my cases has been such as the patient seemed to need, without reference to the catarrh.

In obstinate cases, I have used the vapor bath and the wet sheet with success; and in a few cases emetics, with prolonged nausea, and hot foot-baths, which seemed to start the patient towards recovery, who before their use remained at a certain stage a long time without change.

In some cases the throat syringe is essential to remove the scales and mucus from the Eustachian tube and the deep fossæ above it in the pharynx. In a few instances of this character, in cases of catarrh of the tympanum, hearing has been improved from one to twenty inches at one sitting.

In cases of congestive retinitis, where the ophthalmoscope shows the membrane like fine pink velvet upon which a mixture of milk and water had fallen, attended with photophobia and complicated with sclerotico-choroiditis posterior, I have had all the symptoms and signs, except the myopia, change for the better at once; and so great was the benefit in these cases that I use the douche in all catarrhal inflammations of the eye or the lachrymal apparatus.

In some cases of catarrh where the mucous tissue is greatly thickened, where the turbinated bones are changed in character, where ulceration has become a habit, it requires faith and perseverance to succeed; but my experience warrants me in saying to the profession, that but few cases are incurable, if physician and patient will as carefully and persistently continue the means as they do in cases of ordinary acute diseases. It needs faith to infuse enthusiasm in your patient, and without it one will have dull work and very likely a failure.

Bibliographical Notices.

Watson Abridged: a Synopsis of the Lectures on the Principles and Practice of Physic, delivered at King's College, London, by THOMAS WATSON, M.D., Fellow of the Royal College of Physicians, late Physician of Middlesex Hospital, &c. Abridged from the last English Edition. With valuable Additions, by J. J. MEYLER, A.M., M.D. Philadelphia: published by the Author.

THE character of this little volume is best given in the author's own words:—"The principal object," he says, "that induced the making of this abridgment was to afford young practitioners, who are often at a loss what to do on their first 'sick call,' and country and other physicians, whose numerous professional duties prevent them from consulting more extended works, a convenient and expeditious means

of reference to their daily rounds. Another, but no less important object was to supply medical students, during lecture seasons, with a ready means of reading over, in a few minutes, the various subjects treated of in his daily lecture by the Professor in Practice."

The young practitioner on his first "sick call," would hardly inspire his patients with confidence in their physician if he had to carry a mentor under his arm to supply a defect of memory, or to clear up his doubts about treatment. Furthermore, our younger brethren usually have leisure enough in their own studies for a more thorough consultation of medical authorities than such a small volume as this can give them, in cases of doubt or great responsibility. We have much sympathy for that "fearful looking for" of cases, with which a beginner dreads the appearance of some rare or obscure form of disease, lest he should be entirely at a loss what to do for it. Nevertheless, it is much better for him in such an emergency to rest upon general principles, and as sure a diagnosis as he can make up out of the sum of his previous knowledge, taking care at least to do no harm to his patient, rather than to lean upon such a prop as this.

The second class of readers for whom this book is intended may find it a useful companion, to jog the memory withal, or in the hurry of overwork to supply for the moment the place of a fuller research. For medical students, to be used in the way indicated, we think it may answer an excellent purpose. It is needless for us to say, that the original work, of which this is an epitome, is one of standard authority, its venerable author being at the present time, if we mistake not, the President of the Royal College of Physicians, and the acknowledged head of the medical profession in England. His work may be said to be the first of the modern books on Theory and Practice, in which a successful attempt was made to give to medical teaching the attraction of an agreeable literary style. The example was a most valuable one, and has been followed in numerous instances since with immense advantage to students. Matter and manner, body and spirit—we cannot, under present conditions, make either available without the other. Too much of the medical literature of the past is simply inert, for the want of the animating spirit which an agreeable literary style alone can give.

Massachusetts General Hospital.

[Surgical Operations for the weeks ending November 23d and 30th. Reported by C. B. PORTER, M.D.]

1. *Lipoma of Back.* By Dr. H. J. BIGELOW.—Patient was a young man. This tumor, situated between the right scapula and spine, was of the size of a large cocoa-nut, had existed for ten years, and of late had been rapidly growing. It was excised, and parts united by sutures.

2. *Tumor of Breast.* By Dr. H. J. BIGELOW.—The patient was a large, stout, married woman, 61 years of age. The tumor had existed one and a half years, and presented, upon examination, a hard, rounded mass of the size of a closed fist, occupying the region between the mammary gland and the axilla. It was attached to the gland and surmounted by several enlarged glands in the axillary space. The tumor was excised, with the whole of the breast from which it sprung, and the enlarged axillary glands were then removed. The wound

thus left, which was of unusual size, bled freely—some eight or ten vessels requiring ligatures—and was closed by sutures.

3. *Operation for Deformity of Ankle-joint.* By Dr. S. CABOT.—Patient, an adult male, fell, eighteen months before, from a mast of a ship, at sea, striking upon deck, producing compound fracture of both humeri, and driving the bones of the right leg through the foot. He was treated at sea, and recovered with the foot ankylosed at an obtuse angle with the leg, the toes pointing strongly downward. He was unable to walk upon his foot on account of severe pain in the ball of the great toe and ankle-joint. *Operation.*—The patient being etherized, a semi-lunar incision was made over the inside of the tibia, just above the internal malleolus, and a wedge-shaped piece of bone nearly the whole thickness of the tibia removed. The fibula was then exposed by a similar incision on the outside, and the bone sawed through. Sufficient force was then applied to fracture the remaining posterior wall of the tibia, and the foot brought to a right angle with the leg. The wounds were brought together by sutures and dressed with lint wet in a solution of carbolic acid, and the leg placed upon a Goodwin splint.

4. *Enchondroma of Finger.* By Dr. H. J. BIGELOW.—The patient, a carpenter by trade, 28 years of age, had an enchondroma of fourteen years' growth, of the size of a horse-chesnut, growing from the first phalanx of the left forefinger on its inner side, a smaller mass occupying a similar position on the distal phalanx. After learning the liability of this disease to recur locally after excision, the patient decided to submit to the removal of the finger, which was amputated at its metacarpal articulation by the oval method, and the head of the metacarpal bone was subsequently removed obliquely with the forceps.

5. *Fistula in Ano.* By Dr. S. CABOT.—Patient, an adult, had been operated upon before entrance to hospital, but unsuccessfully. The fistula was laid open and stuffed with lint.

6. *Perineal Section.* By Dr. H. J. BIGELOW.—This patient, an adult, had been troubled with stricture for many years. The stricture admitted with difficulty a No. 3 bougie, and had resisted various treatment, including dilatation and internal incision. The bladder was now becoming diseased. *Operation.*—The patient was placed in the position for the operation of lithotomy, Syme's staff having been previously introduced. An incision being made through the perinaeum upon the staff, the stricture was divided and a probe introduced, by the side of which an elastic catheter was guided into the bladder. It entered, however, but a few inches, and as no urine could be made to flow through it by pressure as usual above the pubes, it was suspected that the catheter had become occluded, or that perhaps it had not entered the bladder; it was therefore withdrawn, and as it seemed to be free was again introduced, with similar result. An examination by the rectum now showed that the catheter was actually in the bladder, which was, however, thickened and so contracted that while it admitted the catheter but a few inches, it contained little or no urine. The catheter was secured in place by adhesive straps, as usual, to the penis, beyond which it projected some four or five inches. Dr. Bigelow remarked that while the bladder could be readily reached in a short time, as in the present case, where the stricture admitted a staff, yet in other frequent cases involving a small and irregular stricture, the operation required great care and deliberation, with cautious dissection; the chief points of the operation being—an incision exactly upon the median line; equal traction upon the two sides of the incision, so that while the parts are drawn neither to one side nor the other, the dissection, sometimes deep, shall be fully exposed to the eye of the operator; a single clean incision of the urethra, to be insured by holding the knife in place when once entered upon the staff in front of the stricture, until the lips of the urethral wound can be seized and held apart, so that the edges of this wound shall not be hacked in the endeavor to find it again if the orifice be once lost by the withdrawal of the knife. He also directed attention to the importance of exactly dividing the stricture, however irregular and small, through its entire length, and of dividing none of the tissues between the stricture and the bladder.

7. *Tumor of Breast.* By Dr. S. CABOT. Patient was a married woman, aged

34 years. Tumor had existed one year, and was about the size of an orange. There were numerous enlarged glands in the axilla. The tumor, with the breast to which it was attached, was excised, and the enlarged glands carefully dissected out. The bleeding vessels being tied, the wound was closed by sutures.

8. *Tumor of Forearm.* By Dr. H. J. BIGELOW.—Patient was a negro, who had received a blow upon the radius above the wrist, two years before. Being in the cavalry service, the use of this, his sword arm, had gradually developed a concentric tumor on the substance of the radius, some three inches in diameter. Fistulous openings, discharging pus, had existed in this tumor about eighteen months. Dr. Bigelow stated that, notwithstanding the existence of these fistulous openings, the unusual size of the tumor led to the conviction that it was not simple necrosis, but something in the nature of transformed tissue, either malignant or benign. The patient desired an exploratory operation, but would not submit to an amputation at present, were it deemed necessary. The interior of the tumor, when explored by the finger through an incision, was found to be occupied by firm and ragged masses of bone, like some volcanic scoriae. No soft material could be procured for examination, but the lesion was supposed to be an exceptional form of malignant disease.

9. *Urethral Stricture.* By Dr. H. J. BIGELOW.—Patient was a male, aged 33 years. The stricture, of traumatic origin, was of one and a half years' duration. Patient suffered great pain in the region of the bladder and perineum, and had frequent micturition. The stricture, which admitted a very small bougie, was so sensitive that its examination was deferred until the patient should be etherized for operation. The bladder was so inflamed that for months the patient had been compelled to void his urine every half hour. The patient was brought into the theatre for the purpose of performing perineal section, but the stricture proved to be so short and brittle that a series of bougies were successively introduced into the bladder, and a No. 9 catheter was left in place in the urethra, to protect the lacerated surfaces until they should be themselves protected by lymph.

10. *Re-amputation of Leg.* By Dr. H. J. BIGELOW.—Patient, a male, aged 28 years, had had his leg amputated three and a half years before, for wound, on the battle-field. He has never been able to wear an artificial leg, on account of great pain in stump. There was an ulcer on the outer aspect of the stump, of some months' duration, which refused to heal. Re-amputation by the circular method was performed about three inches from the end of the stump, the vessels tied and the wound closed by sutures.

11. *Fistula in Ano.* By Dr. H. J. BIGELOW.—Fistula, of three months' duration, was laid open.

12. *Hæmorrhoids, external and internal.* By Dr. H. J. BIGELOW.—Hæmorrhoids were tied.

13. *Amputation of great Toe.* By Dr. S. CABOT.—Toe gangrenous, following severe contusion and crushing. Amputated, and the head of metatarsal bone removed with forceps.

14. *Hæmorrhoids.* By Dr. S. CABOT.—Patient was an adult male; the hæmorrhoids of ten years' duration. Three were tied with a double ligature.

15. *Fistula in Ano.* By Dr. S. CABOT.—Patient was an adult male. Fistula laid open.

A LARGE gathering of physicians took place at Delmonico's on Tuesday evening, the 10th ult., to commemorate the anniversary of the Society for the Relief of the Widows and Orphans of Medical Men. An elegant dinner was served, and a band of music added to the attractions of the evening. Toasts and speeches were made, and great good feeling prevailed. About \$3000 was received from new members, and the sum of \$500 from a friend who modestly did not wish his name announced. The best speech of the evening was from Mr. Choate, who responded for the law. Speeches in response to toasts were also made by Rev. John Cotton Smith, Dr. Detmold, Dr. Hewit, Dr. Howard and others.—*N. Y. Medical Gazette.*

 THE BOSTON MEDICAL AND SURGICAL JOURNAL.

 BOSTON: THURSDAY, DECEMBER 5, 1867.

 EXTRACT FROM A MEMOIR BY DR. ARCHAMBAULT ON "TRACHEOTOMY
IN THE LAST STAGE OF CROUP."

A PAPER on tracheotomy in the last stage of croup, by Dr. Archambault, Physician to the *Hopital des Enfants*, appeared in the July numbers of the *Union Médicale*. We translate a portion of it.

* * * From the foregoing statements I arrive at the conclusion already pronounced by others, that the chances of success from the operation of tracheotomy in croup, are fewer, the younger the infant; that they increase with the age of the subject; but that in no case should any age be taken as a counter-indication for it.

Is the operation indicated in any way by the constitution or the temperament of children? And are we to expect that children who are robust, and have a sanguine temperament, will be more likely to recover than others? The cases which have occurred in my own practice would incline me rather towards the opposite opinion. It has seemed to me that those who were somewhat feeble, of lymphatic temperament, were attacked less violently by the croupy affection. In them, it has seemed to me that the inflammatory element played a very secondary part; that there was less intense reaction; that the extension to the bronchial ramifications was less rapid and less profound, and tended to put on rather a catarrhal character, which ought to favor the separation of the false membrane, together with its expulsion by the aid of the bronchial secretions. The previous tendency of the patient to bronchial secretions of a catarrhal character has seemed to me a good omen, and I have always learned with satisfaction that, while in other respects healthy, he was apt to be "stuffed" (*poitrine grasse*)—an expression which, in the mouth of the parent, signifies that the bronchi are the seat of an abundant catarrhal secretion.

The truth of these ideas is not susceptible of rigorous demonstration, even by the aid of detailed observations. They have already been advanced by others, who have not succeeded in further proving their reality. But, if each observer recognizes them as the expression of the facts in the case, they will eventually attain a real prognostic value.

I am free to express my thoughts upon this point as follows, viz. :—In robust children, with a sanguine temperament, tracheotomy offers fewer chances of success than in those who present different conditions. The more abundant are the catarrhal secretions of the bronchi, the more probable is the cure.

Is a confirmed diathesis, which is well established by appropriate manifestations, a counter-indication? It is difficult to reply to so general a question. Yet, I think we may often get round it on the ground that opening the trachea is an operation of necessity, the employment of which comes in only after resort to all other measures. Furthermore, facts come to the aid of *à priori* reasoning to furnish the conclusion. Thus, the younger Auroux, who recovered so well, bore indubitable traces of scrofula, a diathesis which has since manifested itself under

the aspect of Pott's disease, for which he has been treated by Bouvier. The younger B—, on whom I operated *in extremis*, had coxalgia, which resulted in false joint; and, in addition, there had been observed at the top of the chest signs which permitted a belief in the existence of tubercles. Before operating, I was able to diagnosticate, though hastily, dulness at the summit on the right side; and I have since discovered in this region, prolonged expiration and mucous râles (due chiefly to catarrh). This child had also become emaciated for a certain time before its seizure with croup, and was very pale. Thus, a combination of circumstances rendered it fair to regard the patient as phthisical, and consequently to reject the idea of an operation. At the same time, what I learned from the statements of others, and by personal observation, did not deter me from an operation, the immediate result of which was to be the prolongation of life, for some hours at least. The inspiration of the moment was a happy one, since the child has now become a young man, whose health is at present in an improved condition.

No doubt if croup were developed in a patient who presented in large measure the physical and rational signs of pulmonary phthisis, it would be warrantable to refrain from an attempt to diminish the suffering of asphyxia by the introduction of the canula. Still we must not set up too absolute a rule of non-intervention under these circumstances, lest we should err in so doing. I found myself in attendance upon a woman evidently phthisical, and who was sinking under a terrible struggle arising from an almost complete closure of the larynx. The anguish of the unhappy patient was so frightful that I had not the courage to refuse her what benefit she could expect from the operation—that is to say, the free access of air which she needed. She retained the canula six weeks, and sunk under the consumption. Before the operation, I did not know exactly whether we were dealing with œdema of the glottis or with croup, although there was false membrane on the glottis. But the patient subsequently expelled diphtheritic products in such considerable quantity and so highly organized, that there was no longer any doubt about the croupy nature of the occlusion. There was thenceforth strong reason to believe that the bronchial ramifications were invaded to a great extent, and that the diphtheritic affection was about to bring on the catastrophe. It was not so, however. After the expulsion of tubular false membranes for a couple of days, muco-purulent matter only issued through the canula, and death was caused by tubercular consumption, about six weeks after the operation.

Many other circumstances, also, are of a nature to task the judgment of the practitioner; and the course to be pursued, when they occur, is rather to be determined by experience than by positive rules. One of those things with which I charge my mind in examining a child attacked with croup is always to endeavor to ascertain if the bronchial ramifications be invaded by false membranes, and to what extent. I must confess that I have never found it possible to solve either part of this problem. Feebleness of the vesicular murmur, or its absence, at certain points of the chest, might indeed permit the supposition of false membranes obliterating the bronchi corresponding to those points. But, the verification of this negative auscultatory phenomenon is rare.

On the other hand, if the respiration be heard everywhere, have we a right to conclude that the bronchi are not lined with false membrane? Not at all! For

the membrane may not be sufficiently thick to close those bronchi which are of a certain calibre: and, in fact, this must be the case in the majority of instances. The existence of the so-called *bruit de drapeau* must be a rare exception, since its production exacts an exceptional condition—that is to say, the presence of a piece of false membrane peeled off and floating in a bronchus. A consolation in this our inability to know the extent to which the air tubes are affected is, that the question of the diagnosis, though solved, would have at most but a limited prognostic value. The cases where there is extension of the false membrane to the bronchial ramifications would be considered less favorable, but would not indicate a rejection of the operation, since instances of recovery after the expulsion of ramified false membranes are far from being rare.

It would be unquestionably more important to know, before operating, if the croup were complicated with broncho-pneumonia; for this latter affection appears to me to afford one of the most weighty motives for avoiding tracheotomy, since the peculiar conditions under which respiration takes place through the canula appear of a nature to favor the development of a broncho-pulmonary phlegmasia, and, by consequence, to aggravate that ascertained to exist at the time of operating. The diagnosis, which at first may seem to be rendered very simple by means of percussion and auscultation, is, on the contrary, extremely difficult. Percussion, very useful in the recognition of an outright lobar pneumonia, is of very questionable utility, not to say worthless, in searching for the nuclei of congestion characteristic of broncho-pneumonia; and is not to be depended on as a means of escape from our embarrassment.

As to auscultation, we must not forget that the peculiar character of laryngeal respiration in croup interferes with the usually very positive data of that art. Either the laryngeal *sifflement* is sufficiently strong to mask all the phenomena of auscultation, or else the column of air which gains admittance to the lungs is too inconsiderable to produce the ordinary auscultatory sounds. Most frequently the result is uncertainty.

Lobar pneumonia is more easily diagnosticated by means of the *souffle* and the dulness, although, nevertheless, error is quite possible in that. Thus, the *souffle* might be masked by the reverberation of the laryngeal *sifflement*, and dulness might be perceived just before the operation, and disappear immediately after the free entrance of the air. This would be a physical phenomenon peculiar to these cases, and which would not depend on its habitual causes; that is to say, on pulmonary induration, or pleuritic effusion.

M. Millard has cited from his own experience an example of this false dulness, and has borrowed one from M. Chassaignac. To this double testimony I will add mine. In two instances I have been able to ascertain the actual existence of a dulness which I did not find again after the canula had permitted the free entrance of the air. To what this dulness is due, is a question which I cannot answer.

If the study of the physical signs does not permit us to set up a positive diagnosis, an attentive observation of the character of the respiration, and of the fever, will often allow of our deciding almost certainly as to the existence of a pulmonary phlegmasia. The habitual character of the croupy dyspnoea consists less in the frequency of the respirations than their difficulty, and in its deploying very energetically all the inspiratory forces. M. Barthez has distinctly set forth

in his work, that the respirations do not rise above 48, a figure which he fixes upon as the extreme limit. In the pulmonary phlegmasiæ, and notably in broncho-pneumonia, as M. H. Roger has pointed out, the dominant characteristics of the dyspnœa consist especially in the frequency—the extreme rapidity—of the respiration.

If the croup is complicated with a phlegmasia of the little branches, or of the pulmonary tissue, the respiration takes on a mixed character. To the difficult respiration arising from the laryngeal impediment, is added a frequency, a rapidity of inspiratory efforts, which depends on the condition of the pulmonary bronchi. M. Millard, who is an excellent observer, has laid down this peculiarity, and has, so far as I know, been the first to attribute to it an important diagnostic value, which he sums up in this practical formula, viz.:—"Whenever a child attacked with croup respire oftener than fifty times a minute, the practitioner should be on his guard and explore the chest with care." If there were not exceptions to every rule, I should add that in all these cases the medical attendant should consider it certain (even if the examination of the chest should reveal nothing definite) that there exists a broncho-pulmonary phlegmasia; and, in fact, such is also the idea of M. Millard. Six times I have seen this special frequency of the respiration before operating, and in each of the cases I have been able to identify the signs of broncho-pneumonia a little while after the operation. All the children who were thus affected died quite rapidly; and I have come to asking myself if it be really wise to operate upon an infant whose inspirations rose above fifty per minute. But, it must be considered that, after all, the most scrupulous analysis and the nicest weighing of the symptoms cannot furnish an absolutely certain diagnosis of broncho-pneumonia, and that were such a diagnosis fully set up, we could not positively infer that the operation would fail of a happy result. I must, however, repeat that I have always seen death follow under such circumstances, though the cases I have had, added to those of other observers, do not altogether make up a sufficient number on which to found a rule of abstinence. I subjoin, in relation to the influence of broncho-pneumonia, the following remarks upon the prognosis, viz.: inflammation existing at the time of the operation, as I have just said, I have always found to be fatal, and the subjects of it have not even experienced any considerable alleviation of their distress. The respiration has continued nearly as frequent after as before the opening of the trachea, and has merely become less difficult through the disappearance of the strain upon the larynx. The broncho-pneumonia which supervenes shortly after the operation—most frequently during the first two days—is usually fatal, and it may be said that by far the greater part of those operated on are carried off very rapidly. I have seen only one recovery under such circumstances—that of the younger Vautrin, who after doing well the first day, was seized, during the succeeding twenty-four hours, with a febrile exacerbation, dry cough, and an acceleration of the respiration, which reached to 60 per minute. Auscultation of the chest demonstrated quite fine sub-crepitant râles at the base of both lungs and a little resonance. In the right lung, there was a spot where even a soufflé was heard. Revulsives, stopping short of vesication, a draught containing a slight proportion of Kermes mineral, the free ingestion of liquids, and inhalations of vapor, promoted the resolution of this catarrhal phlegmasia,

which terminated with an abundant secretion. The infant was in great danger, however, for four or five days.

In place of showing itself on the second day, the broncho-pneumonia may not supervene till later, at an epoch when the pulmonary tissue seems to be accustomed to the new conditions of inspiration imposed upon it. Under these circumstances, the results are much less dire. The younger Delage was not seized until the fourth day; Masson was attacked also on the fourth; Bourgeois on the seventh; the latter at the moment when I was about to withdraw the canula, a measure which could not, therefore, be resorted to till the sixteenth day. The life of these children was no doubt placed in great peril, but they finally recovered, thus authorizing me to say that we must not despair because we see a pulmonary phlegmasia supervene, if it be at a comparatively late period after the operation.

Is a lobar pneumonia existing on one side a formal contra-indication against the operation called for by the laryngeal asphyxia? I have never found myself face to face with a case of this nature, and I do not know that those who have operated have been fortunate enough to obtain success. The best result at which M. Guersant has arrived is, to prolong life a sufficient number of days to cause recovery to be looked upon as possible. This is little, doubtless, but it is again in order to recall here the fact that we are dealing with an operation of necessity, which has, at least, the effect of delaying death. * * *

The Massachusetts College of Pharmacy propose to inaugurate during the coming season, a course of Lectures on Chemistry, Materia Medica, Botany and Pharmacy, and offer to the apothecaries of New England an opportunity so long desired, to improve and perfect themselves in their profession, and ask their attention to and coöperation with the plan. The course will commence with an introductory lecture, to be delivered by Samuel M. Colcord, Chairman of the Board of Trustees of M. C. P., on Wednesday evening, December 11th, 1867, at 7 1-2 o'clock, at the room of the College, No. 12 Temple Place, which will be free to all, ladies included. The regular course of instruction will consist of Lectures to be delivered, as follows:—On Chemistry, by E. L. Stoddard, Ph. D., Instructor in the Laboratory of the Massachusetts Institute of Technology; on Materia Medica and Botany, by C. M. Tracy. The Course of Materia Medica will be introduced by Edward H. Clarke, M.D., Professor of Materia Medica in Harvard University; on Theory and Practice of Pharmacy, by George F. H. Markoe. All the Lectures of the Course are intended to be practical, and will be given with special reference to Pharmacy.

MESSRS. EDITORS.—In your last week's notice of Mr. Lawson's "Injuries of the Eye, Orbit and Eyelids," the test types printed with the book are "said to be corresponding to those of Prof. Ed. Jäger." I would call attention to the fact that they do not in any way correspond to Jäger's test types, which are a series of 20 types increasing regularly and progressively in size. Those of Mr. Lawson, repeated in the American reprint, are only 13 types, without anything very definite about them except that each after the first, is larger than the preceding one. The peculiar shape of the letters and their arrangement *entirely preclude* them from being used to obtain any definite measure of vision. I believe the difficulty still exists which I formerly found, namely, that our type-founders have not the types corresponding to Jäger's sizes or to Snellen's, requiring therefore the cutting of a plate, which Prof. Jäger was obliged to do with some of his, published in the following languages, and printed by L. W. Seidel & Son in Vienna—Spanish, Portuguese, Russian, Polish, Italian, Greek, Hebrew, German, French, English.

B. JOY JEFFRIES.

Boston, Nov. 30, 1867.

New Medical Publications.—The medical publishers, Messrs. Lindsay & Blakiston, of Philadelphia, inform us that they are about issuing a translation by M. J. DeRosset, M.D., Adjunct Professor of Chemistry in the University of Maryland, of "Bouchardat's Annuaire de Therapeutique, Pharmacologie," &c. &c., with additions; to form a neat 16mo. volume. The publishers tell us it has a very wide circulation over the continent of Europe, and that there will no doubt be an extensive demand for it in this country. It is promised about the first of January.—The same publishers will also issue about the same time the Pioneer Volume of Hospital Reports in the United States, to consist of "Reports of Cases and Clinical Lectures by the Medical and Surgical Staff of the Pennsylvania Hospital," with an introductory article on the history of the Hospital, to which are added some Reminiscences of the Physicians and Surgeons who have served it. The edition will be limited, and the price to subscribers one dollar less than the regular selling price.

A FRIEND sends us the following query:—A person drops suddenly dead; what are the peculiar or particular symptoms which enable an officer—say a coroner—to decide that the death was caused by "disease of the heart," no autopsy being made?

VITAL STATISTICS OF BOSTON.

FOR THE WEEK ENDING SATURDAY, NOVEMBER 30th, 1867.

DEATHS.

	Males.	Females.	Total.
Deaths during the week	66	49	115
Ave. mortality of corresponding weeks for ten years, 1856—1866	42.3	41.8	84.1
Average corrected to increased population	00	00	92.66
Deaths of persons above 90	0	0	0

NOTICE TO SUBSCRIBERS.—In two or three of the first weekly issues of December, bills will be enclosed to the subscribers of the JOURNAL. These bills comprise the current year of each subscriber, and some of them, as those interested will perceive, also include a period back, which has been comprised in one or more previous but still unsettled accounts. It is earnestly desired that bills of the latter class receive immediate attention. Money orders can now be obtained at most post offices, and furnish a perfectly safe mode of making remittances. Where not obtainable, and when for small amounts, bank-bills may be sent at the risk of the publishers. A receipted bill will always be included in the next issue of the JOURNAL succeeding the reception of the money: if a subscriber does not thus receive his receipt when due, he should give information at once to this office.

PAMPHLETS RECEIVED.—Smallpox and Vaccination. By R. M. Lackey, M.D., Chicago. —Progress in School Discipline: Corporal Punishment in the Public Schools—Addressed to the Citizens of Cambridge, by Morrill Wyman, M.D.—Thirty-second Annual Report of the Industrial Aid Society for the Prevention of Pauperism, Boston.—On the Prevalence of Epidemic Cholera in Chicago in the year 1866. By N. S. Davis, M.D., Chicago.—Observations on the Nature and Treatment of Polypus of the Ear. By Edward H. Clarke, M.D., Prof. of Materia Medica in Harvard University, &c.

MARRIED.—At Sutton, Mass., Nov. 6, A. L. Stickney, M.D., to Miss Lizzie A. Hill, both of Sutton.

DIED.—At Scarborough, Me., Nov. 24th, Dr. John M. Milliken, aged 59 years.

DEATHS IN BOSTON for the week ending Saturday noon, Nov. 30th, 115. Males, 66—Females, 49. Abscess, 1—accident, 4—apoplexy, 1—asthma, 1—inflammation of the bowels, 2—congestion of the brain, 1—disease of the brain, 2—inflammation of the brain, 1—bronchitis, 3—consumption, 27—convulsions, 3—croup, 2—diarrhoea, 2—diphtheria, 3—dropsy of the brain, 1—drowned, 2—dysentery, 1—erysipelas, 1—scarlet fever, 18—typhoid fever, 2—gangrene, 1—disease of the heart, 7—infantile, 1—jaundice, 2—disease of the liver, 2—congestion of the lungs, 3—inflammation of the lungs, 7—marasmus, 1—measles, 1—old age, 1—puerperal disease, 2—scalded, 1—syphilis, 1—teething, 1—tonsillitis, 1—tumor, 1—unknown, 4.

Under 5 years of age, 44—between 5 and 20 years, 16—between 20 and 40 years, 24—between 40 and 60 years, 19—above 60 years, 12. Born in the United States, 83—Ireland, 25—other places, 7.